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DATE NOTICE SENT TO ALL PARTIES: Apr/20/2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: OP lumbar ESI Lt L4-5 with fluoro, CT lumbar with contrast, CT reconstruction, X-Ray exam of lower spine, complete epidurogram, supplies

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: D.O., Board Certified Physical Medicine and Rehabilitation and Pain Medicine

REVIEW OUTCOME: Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

[X] Upheld (Agree)
[ ] Overturned (Disagree)
[ ] Partially Overturned (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether medical necessity exists for each health care service in dispute. It is this reviewer's opinion that medical necessity for the proposed OP lumbar ESI Lt L4-5 with fluoro, CT lumbar with contrast, CT reconstruction, X-Ray exam of lower spine, complete epidurogram, and supplies has not been established

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a female who was injured on xx/xx/xx while lifting. The patient developed complaints of low back pain following the injury. This had not responded to physical therapy, the use of oral steroids, or anti-inflammatories. MRI studies of the lumbar spine from 12/05/14 noted no focal disc herniations at any lumbar level. There was 2mm disc bulging at L4-5. There was no evidence of stenosis or nerve root compression. The patient did have electrodiagnostic studies completed on 01/14/15 which noted evidence of a left L4-5 lumbar radiculopathy. The patient was followed by for continuing complaints of pain that was not improved with medications, physical therapy, or a home exercise program. The patient described her pain in the left buttock and low back. There was no indication of any radiating pain below the knee. The patient's physical examination found tenderness in the lumbosacral paraspinal musculature. There was pressure in the left lower lumbar region with straight leg raise testing. Some motor weakness was noted in the left lower extremity. There were absent reflexes in the left knee.

The requested CT studies of the lumbar spine with contrast and reconstruction, radiographs of the lumbar spine, epidurogram, and epidural steroid injection were denied on 02/04/15 as no official imaging studies or electrodiagnostic studies were provided for review. There was no evidence of significant change in symptoms to warrant additional imaging studies.

The requests were again denied on 02/24/15 as there was no evidence of significant neurocompression at the planned level of injection or evidence of progression of symptoms or physical examination findings to warrant imaging studies.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The patient presents with complaints of low back pain radiating to the left buttock. There was no indication of any significant radiating pain to the lower extremities below the knee. The patient's physical examination findings did note some weakness in the left lower extremity with an absent left patellar reflex. MRI studies of the lumbar spine found no evidence of nerve root compression or stenosis at any level of the lumbar spine. The patient's physical examination findings have not been progressive in nature and would not reasonably support further CT imaging or radiographs of the lumbar spine. It is unclear at this point how further diagnostic testing would reasonably provide additional information to help delineate treatment given the unremarkable MRI findings or evidence of progressive neurological deficit on physical examination. The clinical documentation submitted for review does not meet guideline recommendations regarding epidural steroid injections. There was no clear objective evidence regarding lumbar radiculopathy. Although there are positive electrodiagnostic studies, this does not correlate with imaging that found no evidence of nerve root involvement, compression, or stenosis at any level of the lumbar spine. The patient has no complaints of pain radiating below the knees and physical examination findings were not clearly indicative of an active progressive radiculopathy. Therefore, it is this reviewer's opinion that medical necessity for the proposed OP lumbar ESI Lt L4-5 with fluoro, CT lumbar with contrast, CT reconstruction, X-Ray exam of lower spine, complete epidurogram, and supplies has not been established based on guideline recommendations and the prior denials are upheld.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

[ ] ACOEM-AMERICA COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE

[ ] AHCPR-AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES

[ ] DWC-DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

[ ] EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN

[ ] INTERQUAL CRITERIA

[X] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

[ ] MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

[ ] MILLIMAN CARE GUIDELINES

[X] ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

[ ] PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR

[ ] TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

[ ] TEXAS TACADA GUIDELINES

[ ] TMF SCREENING CRITERIA MANUAL

[ ] PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

[ ] OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)